

2011 COBRA OPEN ENROLLMENT FORM

You only need to complete this form if you would like to make Open Enrollment changes effective **January 1. 2011** Please note that the choices you make on this form will remain in effect throughout the remaining 2011 calendar year.

Deadline for to submit form is 12/22/10. Mail form to: City of San Jose, ATTN: HR Benefits/COBRA, 200 E. Santa Clara St., 2nd Floor— Wing Building, San Jose, CA 95113. **OR fax form to: (408) 999—0862.**

 KAISER PERMANENTE − Group #887 BLUE SHIELD HMO − Group #H11756 (\$10 co-pay) Group #H12020 (\$25 co-pay) BLUE SHIELD POS − Group #MH0161 (\$10 co-pay) Group #MH0241 (\$25 co-pay) BLUE SHIELD PPO − Group #975567 (\$10 co-pay) Group #975993 (\$25 co-pay) BLUE SHIELD HMO/POS Provider #: Location: 					DELTA DENTAL PPO - Group #2584 DELTACARE HMO - Group #5643 Dental Provider #: VSP VISION - Group # 12112926 EYEMED VISION CARE - Group # 9681586 EYEMED MATERIALS-ONLY - Group # 9721127 EAP (Employee Assistance Program)							
COBRA Primary Participant Information:												
Social Se	Social Security Number Last Name				First Name				M.I. Date of Birth			
Address			State				Zip Male Female					
Telephone Number Home () Work () Other (Other ()	City Department					Single Married		
		DE	QUEST TO	CO	VER DEP	E NI	DENTS					
	Last Name	KE	First Name	Date of Birth	Social Security Number	M or F	Relationship ID # (See below)	nship Age 19 - 23 FT Student		Please <u>circle</u> the benefit plan type(s) you would like to enroll each dependent.		
Spouse, Dom. Partner										Health Denta	al Vision EAP	
Child								Yes	No	Health Denta	al Vision EAP	
Child	<u> </u>							Yes	No	Health Denta	al Vision EAP	
Are	you or your dependent(s) covere	d under ano	other: Health pla	n : Yes	No							
Relationship ID # 1 - Husband 10 - Wife 13 - Domestic Partners Date of Marriage/ Domestic Partnership Son 104 - Your natural child 105 - Your spouse's child 105 - Court-ordered Guardianship 106 - Child of your Domestic Partner 107 - Court-ordered Guardianship 108 - Legally adopted child 110 - Child of your Domestic Partner 111 - Court-ordered Guardianship 112 - Court-ordered Guardianship 113 - Child of your Domestic Partner 114 - Court-ordered Guardianship 115 - Court-ordered Guardianship 116 - Child of your Domestic Partner 117 - Court-ordered Guardianship 118 - Court-ordered Guardianship 119 - Court-ordered Guardianship 120 - Court-ordered Guardianship 130 - Child of your Domestic Partner 131 - Court-ordered Guardianship 142 - Court-ordered Guardianship 153 - Court-ordered Guardianship 164 - Child of your Domestic Partner 175 - Court-ordered Guardianship 185 - Your natural child 186 - Child of your Domestic Partner 185 - Your natural child 186 - Child of your Domestic Partner 185 - Your natural child 186 - Child of your Domestic Partner 185 - Your natural child 186 - Child of your Domestic Partner 186 - Child of your Domestic Partner 198 - Your natural child 199 - Your natural child 190 - Your nat												
13 - Legally adopted child		Kaiser COBRA Primary Participant Signature Date										

I authorize my health plan carrier to release or obtain medical information on myself and covered dependents to or from health care providers/agencies for the purpose of providing necessary health care services, utilization review, quality assurance, surveys, processing of claims, financial audit or purposes reasonably related to the performance of the agreement or policy. I also agree to be bound by the benefits, limitations, exclusions and other terms of the Group Agreement and any amendments to the Group Agreements. I understand that only my legal dependents, as defined by the City of San José, may be enrolled in my health, dental, and vision, and EAP plans. I declare that all the information provided herein is true and correct.

COBRA Primary Participant Signature:	Date: